DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE MEDICAL SURVEY

OF

BLUE SHIELD OF CALIFORNIA

A FULL SERVICE PLAN

DATE ISSUED TO PLAN: OCTOBER 4, 2006
DATE ISSUED TO PUBLIC FILE: OCTOBER 14, 2006

Final Report of a Routine Medical Survey
Blue Shield of California
A Full Service Health Plan

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a routine medical survey of California Physicians' Services, dba Blue Shield of California (the "Plan") on January 23 – 26, 2006. This is a Final Report of findings and deficiencies from this Routine Medical Survey. The Department conducts a routine medical survey of each licensed health care service plan at least once every three years to evaluate compliance with the requirements of the Knox-Keene Act ("Knox Keene" or the "Act"). The Survey addresses four areas: Quality Management, Grievances and Appeals, Access and Availability of Services, and Utilization Management.

Following the completion of the January 2006 survey, the Department's HMO Help Center notified the Division of Plan Surveys of recent complaints leveled against the Plan. In these complaints, Plan enrollees experienced significant delays in obtaining services and prescriptions that had been approved through Independent Medical Review (IMR). On April 4, 2006, the Department extended its survey to include an additional focused review of the Plan's implementation of IMR decisions.

During this survey, the Department noted problems in the Plan's handling of quality of care complaints arising from enrollee grievances. At that time, the Department's survey contractor, MHU, Inc., provided several recommendations to the Plan to improve tracking and handling of quality of care complaints within a reasonable time frame. Once the Department issued the preliminary survey report to the Plan, but before the Plan responded, an internal Blue Shield staff person contacted the Department and provided details and case logs suggesting a serious back log in resolving quality of care cases filed with the Plan.

As a result, the Department notified the Plan on June 20, 2006, of the intent to conduct a non-routine survey[1], an in-depth audit of the quality of care complaint process. The deficiencies and findings specific to the quality of care issue will be reflected in the non-routine survey report. The anticipated date for public posting is in early November 2006.

BACKGROUND

The Plan was founded in 1939 as California Physicians' Service by the California Medical Association in response to the economic dislocation of the great depression and the threat of a government sponsored health care system. Operations began in 1940 with 20,000 Californians signed up as subscribers and 5,000 Physician Members. In 1946 the company helped found the National Association of Blue Shield Plans, later known as the Blue Cross and Blue Shield Association.

The Plan was licensed as a California Health Care Service Plan in July 1978 and was one of the four original licensees under the Act. The Plan was permitted the option to include its Preferred

[1] An examination or survey is additional or non-routine for good cause for the purposes of Section 1382(b) when the plan has violated, or the Director has reason to believe that the plan has violated, any of the provisions of Sections . . . 1370. [Rule 1300.82.1(a)(2)]

Provider Organization (PPO) products under the jurisdiction of the Department of Corporations, the state regulatory agency for the Act at that time. The Plan offered its PPO products on a statewide basis and has continued to develop and offer a wide range of PPO benefit design options to enrollees.

The Plan's evolution into a Health Maintenance Organization (HMO) benefit design began in 1987 with a filing reflecting an intention to offer the Plan's new HMO products in Sacramento. In 1996 the Plan introduced its Access+ HMO^{SM}, which, for the first time, enabled HMO enrollees to self-refer to specialists in their personal physician's medical group.

In July 1997 the Plan purchased CareAmerica Health Plans, approved by the Department of Corporations in November 1997. In June 2000, in compliance with the requirements of AB 88 (California Health and Safety Code section 1374.72), the Plan entered into a contractual arrangement with U.S. Behavioral Health Plan, California ("USBHPC") for USBHPC to arrange for and be responsible for all covered in-network mental health and substance abuse services provided to enrollees. The Plan contracted with USBHPC as a Knox-Keene licensed specialized health care service plan. Under the terms of the Group Service Agreement, USBHPC serves as the mental health and substance abuse Administrator, as well as the provider for HMO enrollees and for in-network services for PPO enrollees. The Plan continues to be financially responsible for all out-of network PPO and Point of Service services.

The Plan's licensed HMO service area includes all or part of 35 counties and the Plan has a statewide licensed service area for PPO. Blue Shield offers Medicare +Choice (Medicare Advantage) coverage in four Southern California counties. The Plan currently offers the following products:

- Individual and Group HMO and PPO benefit designs (PPO includes HAS-eligible high deductible plans)
- EPO for Healthy Families and CalPERS in designated counties
- Medicare Supplement Plans
- Medicare + Choice
- MRMIP[2]
- Healthy Families
- Ancillary Products - Dental, Vision

The Plan's corporate headquarters is located in San Francisco. The Plan has approximately 3,500 employees located in San Francisco and at the Plan's major operations centers located in El Dorado Hills, Lodi and Redding and the Medicare operations center located in Woodland Hills.

[2] The Major Risk Medical Insurance Program (MRMIP) is administered by the California Major Risk Medical Insurance Board. For information see the website at www.mrmib.ca.

SURVEY RESULTS

Survey Deficiencies

The Department identified five compliance deficiencies during the current routine medical survey which were listed in the Preliminary Report dated May 29, 2006. Each deficiency indicates an element of non-compliance with the requirements of the Act.

At the time of this Final Report two deficiencies have been corrected and three deficiencies have not been fully corrected. The Department has determined the Plan has not had sufficient time to demonstrate full compliance on the three deficiencies not corrected. The Plan will be contacted by the Department within 60 calendar days of receipt of this Final Report to review the status of these deficiencies and additional actions required.

Refer to Section II for further details of the survey deficiencies identified during the current survey and Appendix A, "The Medical Survey Process", regarding corrective action response requirements.

Survey Findings

In accordance with Section 1380(g) of the Act, Department analysts shall offer such advice and assistance to the plan as deemed appropriate. This Final Report references such advice and assistance in the form of survey findings. Members of the survey team are in a position to identify weaknesses in Plan operations that have potential to become deficiencies in the future. Section III of this report references survey findings offered for consideration by the Plan. Action should be taken as appropriate to benefit the Plan and its enrollees.

SECTION I. SURVEY HISTORY

The table below is a schedule of survey activities conducted by the Department at the Plan in the past three years.

TABLE 1

SURVEY ACTIVITY	DATE
2003 Routine Survey On-Site Visit	January 27- 31, 2003
2003 Preliminary Report	April 11, 2003
Final Report for 2003 Routine Survey	July 17, 2003
Follow-Up Review Report Issued to Plan	January 27, 2005
2006 Routine Survey On-Site Visit	January 23 – 26 and April 4, 2006
2006 Preliminary Report Issued	May 19, 2006
Final Report for 2006 Routine Survey	October 4, 2006

See Appendix B for a list of Enforcement Action(s) taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

SECTION II. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

Table 2 below lists deficiencies identified during the current survey. The Plan received a Preliminary Report regarding these deficiencies dated May 19, 2006. In that report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 2

SUMMARY OF 2006 SURVEY DEFICIENCIES		
#	**DEFICIENCY STATEMENT**	**STATUS**
GRIEVANCES AND APPEALS		
1	**The Plan does not consistently provide a clear and concise explanation of the Plan's decision.** [Rule 1300.68(d)(3)]	Not Corrected
2	**The Plan does not immediately and consistently notify the complainant of the right to contact the Department regarding the urgent appeal.** [Rule 1300.68.01(a)(1)]	Corrected
3	**The Plan does not consistently implement IMR decisions in a timely manner.** [Section 1374.34(a) and Section 1367.01(h)(3).]	Not Corrected
UTILIZATION MANAGEMENT		
4	**The Plan does not consistently provide the Utilization Management (UM) criteria used or clinical reasons for denial, delay, or modification decisions.** [Section 1367.01(h)(4)]	Not Corrected
5	**For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service.** [Section 1368(a)(5)]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

GRIEVANCES AND APPEALS

Deficiency #1: **The Plan does not consistently provide a clear and concise explanation of the Plan's decision.**

Documents Reviewed:
- 12 complaint files dated April 1 to October 31, 2005

Criteria: Rule 1300.68(d)(3)

Conditions: The Department reviewed 12 complaints received by the Plan from April 1 to October 31, 2005 and found that four resolution letters were unclear and/or incomplete. In one example, an enrollee complained about the service of an ancillary provider and requested assistance in finding another provider. The resolution letter simply restated the issues but did not offer any assistance. In another case, the resolution letter did not address the "appeal" of the enrollee for a second mammogram.

TABLE 3

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Complaints	12	Clear and concise explanation for the Plan's decision	8	4

Implications: Complete resolution of the issue grieved and the clear written communication of the resolution to the enrollee are essential components of a fair and effective grievance system.

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan has implemented the following actions (in chronological order) to address and correct the stated deficiency:

A. In March 2006 all Appeals and Grievance Department staff were required to attend the Department's training on IMR and Member Response letters. Those who were unable to attend the training were given make-up training by their director on 4/5/06 in Los Angeles and 4/19/06 in El Dorado Hills.

B. In June 2006 revision of the complaint template letter was finalized to allow for more personalization in the member response. A new job aid was completed to provide assistance to coordinators in handling member complaints. A training session was held June 9th to instruct coordinators on

how to use the new template and job aid. Examples of previous cases will be used to illustrate how the letter has been enhanced, using the new template and job aid, to provide additional clarity to the member.

C. Oversight of the new process will be initially provided by a 100% desktop review of each complaint letter by a Team Lead or Supervisor for a minimum of 30 days to ensure training is successful. At the end of 30 days, if compliance is met, complaint letters will be monitored through the existing letter audit process. Each week, on a concurrent basis and prior to release to the member, a random sample of letters is audited for each coordinator. Immediate feedback is given and letters revised prior to mailing. Analysis and trends will be identified on a monthly basis and corrective action implemented as needed. Quality performance is part of each coordinator's yearly goals and objectives.

The Plan submitted the following documents:
- The Department's Training Presentation
- List of attendees (3/06, 4/06, 5/06)
- List of attendees (6/06)
- Complaint Letter Template
- Job Aid: Processing a Member Complaint
- Job Aid: Letter Audit
- Desktop Review Check List

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Plan has implemented a number of process improvements, retrained staff, and revised the letter template to allow for better customization of its response to enrollees. While the Plan has implemented these changes, the Department has determined the Plan has not had sufficient time to monitor and demonstrate full compliance.

The Plan will be contacted by the Department within 60 calendar days of receipt of this Final Report to review the status of this deficiency and additional actions required.

Deficiency #2: **The Plan does not immediately and consistently notify the complainant of the right to contact the Department regarding an urgent appeal.**

Documents Reviewed:
- Ten expedited appeal files dated April 1 to October 31, 2005

Criteria: Rule 1300.68.01(a)(1)

Conditions: Upon receipt of an expedited appeal, the Plan's policy is to notify the enrollee by telephone of his/her right to contact the Department regarding the appeal and to document the telephone call in the grievance system. However, of the ten expedited appeal case files reviewed, only four documented notification to the enrollee by telephone of his/her right to contact the Department regarding the appeal.

TABLE 4

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Expedited Appeals	10	Immediately notifies the enrollee of his/her right to contact the Department	4	6

Implications: Failure to notify the enrollee of his/her right to contact the Department in response to an urgent grievance prevents the enrollee from exercising other rights under the law

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan has implemented the following corrective actions (in chronological order):

- Appeals and Grievance Department Policy Overview and the Woodland Hills Expedited Appeal Request workflow stipulate that the coordinator is responsible for contacting the member with information regarding the right to contact the Department in response to an urgent grievance. To be documented in Custom View data system.

- Appeals and Grievance Department provided additional individual training on the expedited requirements to the two coordinators assigned to the expedited process on January 27, 2006 and documented in the personnel files.

- The coordinators were reminded of the regulatory requirement to notify members of their right to contact the Department in response to an urgent grievance, and to document the contact in Custom View data system.

- As oversight, randomly selected expedited cases were added to the Quality Compliance quarterly audit process. First quarter audit results were 100% for this element.

The Plan submitted the following documents:
- Appeals and Grievance Department Policy Overview, p 18
- Woodland Hills Expedited Appeal Request, Section 7, pgs 1-3
- Appeals and Grievance Department Clinical Case Form checklist
- Audit results for expedited appeal for notifying enrollee of right to contact the Department 1st quarter 2006 (three cases reviewed)

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based on the Plan's corrective actions, the Department has determined that the Plan has adequately addressed this deficiency. The Department finds that the Plan has retrained staff and submitted the applicable policy and procedure, first quarter 2006 audit results, and the compliance audit tool that facilitate the immediate notification of enrollees of their right to contact the Department in the event of an urgent grievance.

Deficiency #3: The Plan does not consistently implement IMR decisions in a timely manner.

Documents Reviewed:

- 28 overturned IMR cases dated from January 2005 to February 2006

Criteria: Section 1374.34(a) and Section 1367.01(h)(3)

Conditions: The Department reviewed 28 cases selected from the list of IMR cases that have been overturned from the time period January 2005 through February 2006. Of the 28 cases, one was disqualified because the enrollee was no longer eligible for coverage at the time the appeal and IMR were initiated, five were pre-service denials and 22 were post-service denials (with corresponding claims.)

The table below summarizes the Department's findings.

TABLE 5

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
IMR-Overturned pre-service denial	5	Authorize service within five working days of receipt of Department's decision	3	2
		Notify provider within 24 hours of authorization	0	5
		Notify enrollee within two business days of authorization	2	3*
IMR-Overturned post-service denial	22	Reimbursement of services within five workings of Department decision	10	12

*The Plan was unable to provide an actual copy of the letter sent to the enrollee on two of the three files although there was an indication in the Plan's system that a letter was sent within two business days of authorization. The remaining one file had no copy of the letter sent to the enrollee nor was there any indication in the Plan's system that a letter was sent.

When the above findings were discussed with Plan officials, they indicated that gap analysis has been conducted, opportunities for improvement have been identified, and corrective actions have been initiated as follows:

1) Staff assignment changes
2) Assign activity to Medicare Appeals and Grievances Department for better oversight
3) Redesign of process for IMR decision implementation
4) Staff training
5) Audit on 100% percent of IMR overturned cases beginning 4/06
6) Inclusion of the IMR audit activity in the Plan's overall Quality Management Program

Plan officers stated that the Plan also has drafted a new policy and procedure that addresses the issue of timely implementation of IMR decisions that will soon be incorporated into its Quality Management Program. The Plan intends to file an amendment to its Quality Management Program with the Department reflecting the newly established policy and procedure.

Implications: Timely implementation of IMR overturned pre-service denials prevents further delay in the provision of necessary care to the enrollees. Timely implementation of IMR overturned post-service denials prevents undue financial burden on those who have been affected by unpaid claims, which could be either the enrollee or the provider.

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan stated that in early 2006, based on interaction with the Department on several IMR cases, it initiated an analysis of its current process for implementing IMR decisions. Based on the findings, significant deficiencies were identified which prompted process and staffing changes. This occurred prior to notification from the Department that the survey was to be extended to include a focused review of IMR decisions.

The Plan has implemented the following actions to address and correct the stated deficiency:

A. Staff Assignment Changes:

1. The staff at the time this deficiency was identified is no longer handling IMR matters.
2. IMR responsibility was transferred to the Medicare Appeals and Grievances Department staff in Woodland Hills effective 3/27/06. This staff has existing best practices in place for handling external appeals, maintaining compliance with regulatory requirements, and maintaining a positive working relationship with the Center for Health Dispute Resolution[3].

[3] The organization known as Maximus CHDR (Center for Health Dispute Resolution) is a health appeals organization accredited by the Utilization Review Accreditation Commission. Their website at www.maximus.com states: Maximus CHDR is the nation's leading independent medical reviewer of disputed health insurance claims. CHDR serves more than 25 states in the role of review of appeals made by health plan enrollees.

3. The clinical team is also located in Woodland Hills, facilitating enhanced interaction with IMR cases. Appeals and Grievances Department continues to coordinate actual IMR submissions with Plan Medical Policy staff.
4. Additional staff, including a supervisor to monitor daily compliance, was hired.

B. Process Redesign:

1. The IMR process was redesigned from receipt of Request Health Plan Information to implementation of the decision (uphold and overturn).
2. Redesign incorporated detailed compliance with all IMR statutory and regulatory requirements.
3. Pre-service authorizations are now handled in collaboration with clinical Appeals and Grievances Department staff. For HMO patients, IMR results are communicated to the Independent Practice Associations/group and authorizations obtained as necessary. Authorization numbers are included in member and provider letters.
4. For pre-service overturns, a timely process was implemented for notification to member and provider (and, if HMO patient, to Independent Practice Associations/group).
5. For pre-service overturns, a follow-up process was implemented to confirm the authorization was received and understood (e.g., to close the loop and determine that service in question is being accessed).
6. For post-service claims, the process was changed to assure timely and direct processing of involved claims and immediate confirmation of payment. A service level agreement was developed with Claims staff to ensure timeliness.
7. A detailed process was documented in the Appeals and Grievances Department Overview document.
8. A toll-free telephone number was implemented for members to contact appeals staff directly with questions about implementation of IMR decisions. The 800 number was provided to the Department.

C. Training and Auditing:

1. All Woodland Hills IMR staff attended a training session by Department representatives A. George and T. Gilevich.
2. The Medical Policy staff trained the new IMR staff on process on 4/10/06.
3. 100% desk audit of each file was implemented.
4. Beginning 4/10/06, audit of IMR and Department files was added to the formal Plan audit process for Appeals and Grievances Department staff. The results of these audits are shared with the Quality Compliance Department to be included in the regular reporting to the Quality Management Committee. The audit process is outlined in the Appeals and Grievance Audit Policy.
5. Quality audit outcomes are part of staff goals and objectives.

D. Record Maintenance and Reporting:

1. An IMR case check list was developed to document all steps.
2. Copies of all correspondence are maintained in the file and/or on computer systems.
3. Daily reports were developed to allow appeals staff to monitor the process; including tracking of record requests and receipts, verbal and written communications to providers and members, adjustments requests and completions. New tracking codes were developed.
4. Reports are monitored daily by a supervisor to identify and act on any aged items.
5. Record of completed claims processing and follow-up on authorization issues are recorded in files.
6. IMR compliance indicators have been added to the Appeals and Grievances Department and Customer Service dashboards for monthly review by senior management. These management reports are not included due to confidential nature of the data but IMR turn-around time is now reported as a specific metric for review.

The Plan submitted the following documents:

- Appeals and Grievances Department Organization Chart
- Appeals and Grievances Department Policy Overview; IMR, pg. 8
- Appeals and Grievance Audit Policy
- The Department Training Presentation
- The Department/IMR Audit Tool
- IMR audit results for May, 2006
- Summary of IMR Audit Findings
- IMR Case Check List

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that the Plan has not fully corrected this deficiency.

The Plan has implemented a number of process improvements to ensure IMR's are handled appropriately and timely. Once staff training occurred and the process changes were implemented, the Plan conducted an audit in May 2006 to measure the success of the IMR program. While the Plan has implemented these policy changes and conducted an audit in May 2006, the Department has determined the Plan has not had sufficient time to monitor and demonstrate full compliance.

The Plan will be contacted by the Department within 60 calendar days of receipt of this Final Report to review the status of this deficiency and additional actions required.

UTILIZATION MANAGEMENT

Deficiency #4: **The Plan does not consistently provide the Utilization Management (UM) criteria used or clinical reasons for denial, delay, or modification decisions.**

Documents Reviewed:
- 21 medical necessity denials dated from March through October 2005

Criteria: Section 1367.01(h)(4)

Conditions: The Department reviewed a total of 21 medical necessity denials made by the Plan and three delegated provider groups dated from March through October 2005. The review found deficiencies in eight of the 21 denial files. All eight deficient files were from one delegated provider group (Delegate).

The Delegate failed to describe the UM criteria or clinical guidelines used or cite the clinical reasons for making denial decisions. The Delegate's physician reviewers use a worksheet to document the rationale for the denial decision. This worksheet allows the denying physician to check off one of three criteria used to support the denial decision. The criteria box selections are "M&R Criteria" "Health Plan Criteria" and "MD Knowledge". In most of the deficient files, the "MD Knowledge" was checked off, but with no further written explanation. In files where the "M & R Criteria" or "Health Plan Criteria" was checked, there was no documentation of the specific criteria used and how such criteria was applied in the enrollee's clinical situation. Corresponding denial letters were equally deficient. The denial letters sent to enrollees simply stated: "Based on the information provided by the requesting provider, you do not meet the established medical necessity criteria or guidelines for (requested service) at this time."

TABLE 6

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Medical Necessity Denial	21	Cite clinical criteria/guidelines used	13	8
Medical Necessity Denial	21	Provide clear clinical reasons	13	8

Implications: Communicating clearly to enrollees and providers the clinical reasons for denying medical services is an essential component of a fair and reasonable authorization system.

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan stated it performed an audit of Key Medical Group on 2/21/06 following the Department's audit during which deficiencies were noted. A corrective action plan was issued to Key Medical Group on 2/21/06. On 3/28/06, the Plan received the group's response to the corrective action plan and noted that Key Medical Group's Medical Director had been trained to use the Plan's medical policy, criteria or guidelines when appropriate (all available to the provider on-line).

Additionally, the Plan's Delegation Oversight Consultant trained Key Medical Group's Medical Director and registered nurse on the location of online Plan policies and criteria guidelines in addition to access to National Imaging Associates online clinical criteria. The Delegation Oversight Consultant also trained the Key Medical Group staff regarding the Plan's website for provider communication and access to available resources. The Delegation Oversight Consultant reviewed specific cases with the Key Medical Group Medical Director and offered recommendations on appropriate language and citation.

The Plan conducted a second audit on 05/18/06. Key Medical Group showed improved compliance (from 60% to 83%) regarding the provision of clear reason for denial but scored only 70% regarding the provision of criteria or guideline. The Delegation Oversight Consultant noted that some problems centered on radiology studies and therefore bookmarked National Imaging Associates criteria for the Medical Director's reference. An additional audit in July 2006 will be conducted to determine if Key Medical Group has corrected their deficiencies. Key Medical Group will also have their routine annual audit completed in August.

The Plan has requested Key Medical Group to remove from their form the term 'MD knowledge' and only use recognized criteria and practices.

The Plan stated that it is an active participant on the Industry Collaborative Effort[4] UM Service Denial Standardization Team and its staff will be a panel speaker for the Industry Collaborative Effort UM Workshop July 24, 26 and 27, 2006 to assist in training medical groups and Independent Practice Associations personnel. Training material will be available on the Industry Collaborative Effort website: www.ice4health.org

The Plan submitted the following documents:

- Letter to the Medical Group w/Corrective Action Plan 2/22/06
- Acknowledgment of Response from Medical Group 4/4/06
- Re-audit of Key Medical Group report to Network Operations Committee 5/25/06
- Revised Key Medical Group Authorization form

[4] The website of the Industry Collaborative Effort (ICE) at www.ice4health.org states: ICE is a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. ICE volunteers work cooperatively to develop policies, procedures, and tools for physician organizations and other health care providers that enable them to more readily and easily comply with regulations.

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Plan has implemented a training program and conducted multiple audits at Key Medical Group regarding the provision of clear reason and applicable criteria or guidelines on medical necessity denial letters. The Plan's last audit score for Key Medical Group showed an improved compliance score from 60% to 83% regarding the provision of clear reason for denial; however, the delegate scored a low 70% regarding the provision of criteria or guideline. The Department has determined that the Plan has not had sufficient time to monitor and demonstrate full compliance.

The Plan will be contacted by the Department within 60 calendar days of receipt of this Final Report to review the status of this deficiency and additional actions required.

Deficiency #5: **For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service.**

Documents Reviewed:
- Evidence of Coverage relevant to denial decision
- Nine medical benefit denials dated from March through October 2005
- Three pharmacy (medical necessity & benefit) denials dated from March through October 2005

Criteria: Section 1368(a)(5)

Conditions: The Department reviewed a total of 12 benefit denial files -- three were pharmacy benefit denials and nine were medical benefit denials. In five of the 12 benefit denial letters, the Plan did not cite the specific benefit limitation or exclusion in the enrollee's Evidence of Coverage, nor did it clearly and concisely describe the reason for the denial.

TABLE 7

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Benefit Denials (three pharmacy, nine medical)	12	The reason for the benefit denial accurately reflects the provisions of the relevant Evidence of Coverage.	7	5

Implications: A citation to the relevant limitation and/or exclusion in the enrollee's contract document (e.g., Evidence of Coverage) when denying a service on the basis that it is not a covered benefit is an essential component of a fair and effective authorization system.

Corrective Actions: Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency.

Plan's Compliance Effort: The Plan implemented the following to correct the deficiency:

A. On May 11, 2006, managers attended focused training on benefit denial letters utilizing existing Plan Policy on Denial Notices. Plan management recognized the need for a staff guideline specific to benefit denial letter review and processing to promote consistency.

B. On June 2, 2006, a guideline on the Benefit Denial Letter was developed to provide further assistance to staff processing benefit denial letters.

C. On June 2, 2006, the Benefit Denial template letter was revised to incorporate Industry Collaborative Effort benefit denial language to further promote consistency in benefit denial letter review and determinations. The Cover Sheet used by the Clinical Reviewer to describe benefit review determinations was made more explicit prompting the reviewer to include specific references from the enrollee's Evidence of Coverage for benefit determinations.

D. On June 8, 2006, mandatory training took place for non-clinical and clinical staff including medical directors involved with benefit denial decisions. Plan training reinforced Section 1368(a)(5) statutory requirements for the Plan to clearly describe in the benefit denial letter the provisions of the relevant Evidence of Coverage that exclude coverage of the requested service. The training also introduced use of revised benefit denial letter template and guideline and clinical reviewer cover sheet to promote clear and concise citation of the specific benefit limitation or exclusion in the member's Evidence of Coverage in the benefit denial letter and review decision. Examples of previous cases were used to illustrate how the letter had been enhanced making the benefit denial reason more clear to the enrollee.

E. On June 9, a focused audit process for benefit denials was developed to monitor compliance with Section 1368(a)(5) statutory requirements of clinical staff, including Plan Medical Directors. Audit criteria were revised to include assessment of benefit denial letters to confirm that the reason for the benefit denial clearly, concisely and accurately reflects the specific benefit limitation or exclusion in the member's Evidence of Coverage. Random monthly audits will be conducted beginning June 30, 2006 until 100% compliance is achieved. Once full compliance achieved, the Plan will resume the usual audit schedule.

The Plan submitted the following documents:
- Management Training Summary 5/11/06
- Policy and Procedure: Denial Notices
- Medical Operations Guidelines: Benefit Denial Letter
- Benefit Denial Letter template
- Cover Sheet for Request for Review
- Management Training Summary 6/8/06
- Benefit Denial Letter Training, including Medical Directors, 6/8/06
- Staff Training, June 2006

- Benefit Denial Audit Process Summary
- Medical Necessity and Benefit Denial Audit Tool

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

Based on the Plan's corrective actions, the Department has determined that the Plan appears to have adequately addressed this deficiency. The Department finds that the Plan has retrained staff and has revised the applicable letter template to allow for the inclusion of the applicable

SECTION III. DISCUSSION OF SURVEY FINDINGS

The list below summarizes survey findings identified during the current survey. Survey findings do not rise to the level of an actual deficiency. They are offered to advise and assist the Plan in ongoing improvement efforts. The Department considers it beneficial for the Plan to review, evaluate, and take action as appropriate on findings listed in this Preliminary Report.

ACCESS AND AVAILABILITY OF SERVICES

- The Department reviewed the same 21 medical necessity denial files cited in Deficiency #4. Five of these denial files were from one delegated medical group. Two of the five cases were denied claims for urgent care facility visits. The corresponding denial letters for these cases stated: "Your health plan requires that you contact your PCP prior to an emergency room or urgent care facility visit." This statement is inconsistent with the Plan's policy, which states "Blue Shield of California covers emergency services necessary…without prior authorization, in cases where a prudent layperson, acting reasonably would have believed that an emergent condition existed."

- The Department is concerned that inconsistency in communicating Plan policy to both medical groups and enrollees regarding access to emergency care may delay critically necessary medical services, which could cause harm to enrollees.

  The Department suggests that the Plan immediately review its current practices to ensure that all of its delegated medical groups are aware of this policy and it is consistently applied.

Plan's Response: The Plan stated that its HMO Independent Practice Association/Medical Group Manual, which is an integral part of the provider contract, clearly indicates that the HMO does not require prior authorization for emergency services.

In an effort to further educate delegated medical groups and Independent Practice Associations on the Plan's Emergency Services policy, an article on this topic will be included in the next Provider Newsletter, which is scheduled for distribution in August 2006. Providers will be requested to make sure they comply with our policy and do not deny Emergency Services without following the protocol outlined in the Independent Practice Association/Medical Group

Manual, which outlines what must be included in a denial notice to the member in the event Independent Practice Association/Medical Group denies Emergency Services. A Provider Communication Bulletin was sent Winter 2005/2006 regarding patient access.

In the interim, prior to the Provider Newsletter, the Plan further stated it will communicate this information in a memo to providers via an email distribution to all contracted delegated medical groups and Independent Practice Associations by June 15, 2006 as a reminder.

Network Management collaborates with Delegation Oversight Departments in coordinating Regional Joint Operation Meetings for Plan delegated provider groups. In alliance, they will continue education and support for the provider groups by including the issue of access to Emergent/Urgent Services as agenda item and reiterate appropriate guidelines and protocols.

The Plan submitted the following documents:

- BSC HMO IPA/Medical Group Manual: Emergency Services
- BSC HMO Physician Office Manual: Emergency Services; pg 9, Urgent Services; pg. 10
- BSC Provider Communication Bulletin: Important Reminder Regarding Patient Access pg. 5
- BSC Provider Communication E-mail Blast: Emergent/Urgent

SECTION IV. SURVEY CONCLUSION

The Department has completed its Routine Medical Survey of the Plan. Based on the results of this Final Report, the Plan will be contacted by the Department within 60 calendar days from receipt of this Final Report to review the status of deficiencies and additional actions required.

A P P E N D I X A

A. THE MEDICAL SURVEY PROCESS

The Department conducts a routine medical survey of each licensed health care service plan at least once every three years in order to evaluate the plan's compliance with the Knox-Keene Act (the "Act"). Generally, the Department evaluates a plan's performance in four major areas:

(1) **Quality Management** – Each plan is required to assess and improve the quality of care it provides to its enrollees.

(2) **Grievances and Appeals** – Each plan is required to resolve all grievances and appeals in a professional, fair and expeditious manner.

(3) **Access and Availability of Services –** Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.

(4) **Utilization Management** – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

The table below summarizes survey activities and corresponding timeframes.

SURVEY ACTIVITY: PRELIMINARY REPORT	TIMEFRAME
Notification Letter and Request for Documents	Prior to on-site visit
Routine Survey On-Site Visit Conducted	At least once every three years
Preliminary Report due from the Department to the Plan	Within 60-80 days from last day of on-site visit
Report of Correction of Deficiencies due from Plan to the Department [Rule 1300.80.10]	30 calendar days from date of receipt of Preliminary Report
SURVEY ACTIVITY: FINAL REPORT	**TIMEFRAME**
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within ten calendar days from receipt of Final Report. Included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit

SURVEY ACTIVITY: FOLLOW-UP REPORT	TIMEFRAME
Follow-Up Review Conducted	Any time within 16 months of date Final Report issued to the Public File
Follow-Up Report due from the Department to the Plan	No later than 18 months from the date the Final Report is issued to the Public File
Response from Plan to Department on any matters in Follow-Up Report	Within ten calendar days from receipt of Follow-Up Report. Included in Public File with Follow-Up Report
Follow-Up Report due to the Public File [Section 1380(i)(2)]	No later than 18 months from the date the Final Report is issued to the Public File

Survey Preparation
A routine medical survey includes a pre-on-site assessment, a site visit at the Plan, a review of documents, interviews with plan staff and a review of the oversight of the plan's provider network. The survey begins when the Department provides notice and supplies the plan with a questionnaire and a list of documents to be completed and submitted to the Department prior to the on-site visit. Materials are reviewed by the survey team and linked to Plan survey compliance assessments. In advance of the site visit, the Department provides the Plan a list of materials (e.g., case files, reports) to be available to the survey team upon arrival.

On-Site Visit
During the on-site visit, the survey team reviews materials and conducts interviews with plan staff and possibly with providers.

Preliminary Report
Within 60-80 days of the on-site visit, the Department provides the plan with a Preliminary Report, which details deficiencies and survey findings. Preliminary and Final Reports are deficiency and finding-based reports; therefore, only specific areas found by the Department to be deficient or of concern are included in these reports. Omission of other areas of the plan's performance from the reports does not necessarily mean that the plan is in compliance with the Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the plan's performance in other areas.

Plan's Response to the Preliminary Report
All deficiencies cited in the Preliminary Report require corrective actions by the plan. Within 30 days following notice to a plan of a deficiency, the plan is required to file a written statement with the Department (Rule 1300.80.10), signed by an officer of the plan, describing any actions that have been taken to correct the deficiency. For those deficiencies that may reasonably be

expected to require a longer period than 30 days to remedy, a plan may submit evidence that the plan has initiated remedial action to achieve an acceptable level of compliance.

The plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The plan's response to the Department's identified deficiencies, including a corrective action plan;

(2) If the corrective action plan is fully implemented, the plan should provide evidence that the deficiencies have been corrected;

(3) If the corrective action plan cannot be fully implemented by the time the plan submits its response, the plan should submit evidence that remedial action has been initiated and is on the way to achieving acceptable levels of compliance. Include a time schedule for implementing the corrective action and a full description of the evidence the plan will submit for the Department's Follow-Up Review that will demonstrate the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(h)(6). If the plan's response indicates that the development and implementation of corrective actions will not be completed by the time the plan files its response, the plan should file any policies and procedures required for implementation as plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review and consideration of the plan's response to the Preliminary Report, the Department will issue a Final Report. The Final Report will first be issued to the plan, followed by a copy to the public file not more than 180 days from the conclusion of the on-site survey. The report is available to the public by mail or on the Department website at: http//www.dmhc.ca.gov/library/reports/med_survey.

The Final Report will contain the deficiencies and findings as they were reported in the Preliminary Report, a summary of the plan's response and the Department's determination concerning the adequacy of the plan's response. The plan's failure to correct deficiencies

identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Reports on all surveys, deficiencies and correction plans shall be open to public inspection after the Plan is given an opportunity to review the report and respond within 45 days of the date the Plan received the report from the Department. A Final Report will be issued after review of the Plan's response and will exclude any survey information and legal findings and conclusions determined by the Director to be in error, describes compliance efforts, identifies corrected deficiencies and describes remedial actions for deficiencies requiring longer periods to remedy. (Section 1380(h)(2)).

At the same time the Department makes the Final Report available to the public, a summary of the report will be issued to the public file. One copy of the summary is available free of charge to the public by mail. Additional copies of the summary and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The plan may submit additional responses to the Final and Summary Reports any time before or after the reports are issued.

Follow-Up Review
The Department may contact the Plan by letter and/or conduct a Follow-Up Review to confirm correction of deficiencies identified in the Final Report. (See Health and Safety Code Section 1380(i)(2)). Deficiencies left uncorrected will be subject to review and disciplinary action as appropriate pursuant to Health & Safety Code Section 1380(i)(1).

A P P E N D I X B

B. ENFORCEMENT ACTIONS

Below is a list of relevant Enforcement Actions taken by the Department within the past 12 months based on completed investigations where sufficient evidence was found to support allegations that the Plan has committed violations of the Act.

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 270244 **Citation(s):** Section 1367.01(h)(4)	Section 1367.01(h)(4) requires that decisions to deny requested services shall include a "clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity." In this case the denial of the enrollee's request for authorization failed to meet this standard. The Plan delegated to Sutter the responsibility for authorization determinations. Sutter provided erroneous information regarding the authorization denial to the enrollee. As Sutter was the Plan's "delegee," the Plan bears responsibility for Sutter's non-compliance with the Act.	February 24, 2006
Complaint No. 259189 **Citation(s):** Section 1368(a)(5)	Section 1368(a)(5) mandates a plan's written response to subscribers or enrollee's grievances provide "a clear and concise explanation of the reasons for the plan's response." In this case the Plan did not enclose or specify the previsions in the Evidence of Coverage indicating that when a enrollee receives services from a non-preferred provider, the allowable amount that the Plan pays may be substantially less than the amount the provider bills. Based on the Plan's grievance response, the enrollee was misinformed and confused about the Plan's coverage.	January 4, 2006
Complaint No. 241897 **Citation(s):** Section 1363.5 1368(a)(4)(A)	Section 1363.5 requires that the criteria used by a plan, or any entity contracted with a plan, must be evaluated and updated as necessary. In this case the Plan failed to update its criteria used or failed to ensure that the criteria followed by the vendor in this case used the updated criteria. The Plan also failed to acknowledge the enrollee's March 1, 2005 contact with the plan as a grievance, pursuant to Section 1368(a)(4)(A).	January 4, 2006

CITATION	VIOLATION AND ENFORCEMENT ACTION	DATE OF ENFORCEMENT ACTION
Complaint No. 262387 **Citation(s):** Section 1374.34(b)	Section 1374.34(b) requires that plans authorize requested services within five working days of receipt of the written IMR decision and inform the enrollee of the authorization. In this case the Plan failed to authorize the enrollee's medication for forty-seven days and failed to notify the enrollee that his authorization was complete.	January 4, 2006
Enforcement Matter No.: 04-237 **Complaint No.** 234923 **Citation(s):** Section 1368.01(a) Rule 1300.68(d)(3)	Both citations require that the Plan resolve grievances within thirty days of receipt. In Enforcement Matter No.: 04-237, the Plan was eighteen days late in its resolution. In Complaint No. 234923 the Plan was seventy-seven days late in its response.	August 12, 2005 August 2, 2005
Complaint No. 130108 **Citation(s):** Section 1368(a)(5)	Section 1368(a)(5) mandates a plan's written response to subscribers or enrollee grievance provides "a clear and concise explanation of the reasons for the plan's response." In this case the Plan included, **but did not explain**, the relevant sections of the enrollee' Evidence of Coverage.	April 14, 2005
Complaint No. 195022 215126 **Citation(s):** Section 1368.01(a)(5) Rule 1300.68(d)(3)	Both citations require that the Plan resolve grievances within thirty days of receipt and the written response to the grievance must be sent to the enrollee within thirty days. In the first complaint the delay was thirty-two days and in the second complaint it was fifty-four days.	April 8, 2005

A P P E N D I X C

C. OVERVIEW OF PLAN OPERATIONS

The table below summarizes the information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	Full Service, Mixed Model, Not-for-Profit HMO, Point of Service, PPO		
Service Area(s) *(Counties, in full or in parts)*			
HMO/Point of Service	Alameda Butte Contra Costa El Dorado Fresno Kern Kings Los Angeles Madera Marin Mariposa	Mendocino Merced Nevada Orange Placer Riverside Sacramento San Bernardino San Diego San Francisco San Joaquin	San Luis Obispo San Mateo Santa Barbara Santa Clara Santa Cruz Solano Sonoma Stanislaus Tulare Ventura Yolo
PPO	Alameda Alpine Amador Butte Calaveras Colusa Contra Costa Del Norte El Dorado Fresno Glenn Humboldt Imperial Inyo Kern Kings Lake Lassen Los Angeles	Madera Marin Mariposa Mendocino Merced Modoc Monterey Napa Nevada Orange Placer Plumas Riverside Sacramento San Benito San Bernardino San Diego San Francisco San Joaquin	San Luis Obispo San Mateo Santa Barbara Santa Clara Santa Cruz Shasta Sierra Siskiyou Solano Sonoma Stanislaus Sutter Tehama Trinity Tulare Tuolumne Ventura Yolo Yuba

Number of Providers	Primary Care	Specialty Care	Affiliated Medical Groups or IPAs
	19,713	29,968	250

Number of Enrollees as of 11/30/2005	Product Lines	Enrollees
	Group HMO/Point of Service	1,204,155
	Individual HMO	25,716
	Group PPO	684,996
	Individual PPO	265,513
	Healthy Family HMO	35,456
	Healthy Family PPO	5,727
	Total	2,221,563

The paragraphs below present a brief overview of the Plan's operations in each of the four program areas examined during the Department's Routine Medical Survey.

OVERVIEW OF PROGRAMS

QUALITY MANAGEMENT

The Plan's Board Quality Improvement Committee (BQIC), a standing committee of the Board of Directors, has broad responsibility for the Quality Management and Improvement Program (QMIP). The BQIC delegates oversight of the QMIP to the Quality Management (QM) Committee, which defines the scope of the QMIP, monitors access, availability and outcomes of care, identifies and prioritizes opportunities for improvement in care and services, ensures availability of resources to implement the program, conducts oversight of delegated activities, and integrates QM activities at the operational level. The QM Committee is chaired by the Chief Operating Officer and consists of the Chief Medical Officer and senior leadership from Consumer Experience, the IGB Unit and Consumer Operations, and reports to the BQIC quarterly. The support staff for the QM Committee includes the Senior Medical Director of Quality Management and the Director of Accreditation and Credentialing.

The following QM Committee sub-committees report their activities to the QM Committee on a quarterly basis:

- Clinical Quality Improvement Committee, which consists of seven Network Primary Care Physicians, three Network Specialists, and five Plan staff physicians, is the major source of network physician input into the QMIP
- Health Care Improvement Committee
- Continuity of Care Work Group
- Credentials Committee
- Pharmacy and Therapeutics Committee

- Network Operations Committee
- Access and Availability Work Group
- Behavioral Health Oversight Committee
- Behavioral Health Quality Improvement Work Group
- Confidentiality/Privacy Committee
- Member Loyalty Council
- Benefits and Compliance Committee

The QM Committee's oversight of the QM Program includes monitoring all QM committee activities and conducting ongoing analysis of indicators concerning access, clinical care and service. The information/indicators analyzed include complaints/grievances/appeals, member satisfaction survey results, Primary Care Physician survey results, HEDIS®[5] results, population assessments, delegated oversight activities, reviews of UM reports, access and availability metrics, and member service metrics.

GRIEVANCES AND APPEALS

The Executive Vice President of Customer Service and Corporate Marketing has primary responsibility over the Plan's grievance and appeals. The Director, Appeals and Grievances Department is responsible for managing the day-to-day operations of the grievance process.

Customer Service is the main point of intake for oral and written grievances. The Plan accepts enrollee grievances by telephone and in writing. An enrollee may also file grievances by submitting a Grievance Form. Grievance Forms are available by calling Member/Customer Service or by visiting the Plan's web site at www.mylifepath.com. The Plan requires that grievances be acknowledged in writing within five calendar days of initial receipt. Upon investigation and resolution of the grievance, the Appeals and Grievances Department responds to the enrollee/subscriber grievance issue within 30 calendar days of original receipt. Expedited appeals are to be resolved within 72 hours of initial receipt.

Grievances that involve benefits or contractual issues are investigated and resolved by non-clinical coordinators. Grievances that involve clinical issues, whether pre-service or claims related, including medical necessity disputes, experimental/investigational services, and reports of quality of care issues are reviewed and resolved by a Plan Medical Director or an actively practicing practitioner from the same or similar specialty who was not involved in the initial determination.

The Plan provides alternate methods of communication concerning the availability of the grievance process for enrollees who require assistance:

- For hearing or speech impaired: the Plan uses a toll free telephone number that allows hearing/speech-impaired enrollees to communicate with various departments with the Plan.

[5] HEDIS® (Health Plan Employer Data and Information Set) is a set of standardized performance measures designed to provide information to consumers for comparison of the performance of managed health care plans. HEDIS® is sponsored by and is a registered trademark of the National Committee for Quality Assurance (NCQA).

This phone number is published in the Plan's Evidence of Coverage and Member Handbook. Additionally, if a call needs to be made from the Plan to a hearing/speech-impaired enrollee, the Plan uses the California Relay Service in order to communicate with the enrollee.

- For visually impaired: the Plan uses a Braille printer that translates enrollee materials into Braille upon request. Additionally, the Plan has large print materials available to enrollee upon request.

- For Non-English speaking enrollees with verbal communication challenges: the Plan has Customer Service Representatives fluent in Spanish to assist Spanish-speaking enrollees. The Plan also uses AT&T Translator Services to assist in communicating with enrollees in other languages upon request.

- For Non-English speaking enrollees with written communication challenges: the Plan maintains a listing of employees available to translate written correspondence into various languages upon request by an enrollee. Additionally, selected enrollee materials, including a description of the Plan's grievance procedures, are available to enrollees upon request.

ACCESS AND AVAILABILITY OF SERVICES

The Plan facilitates the delivery of health care services through networks of licensed practitioners and facilities. Enrollees access health care services through a HMO, Point of Service or PPO product. Enrollees in the HMO/Point of Service products receive services primarily through a network of Independent Practice Associations and Medical Groups. Enrollees in the HMO product can self-refer to specialists within their Independent Practice Association/Medical Group for a slightly higher co-pay as long as their primary care physician participates in the Access+ Specialist program. Enrollees in the Point of Service product can self-refer to out-of-network services but have a greater financial responsibility for these services. Both Independent Practice Associations and Medical Groups are reimbursed on a capitated basis. Enrollees in the PPO product line can receive services from both in-network and out-of-network practitioners and providers but have a greater financial responsibility for out-of network services. There is approximately 95% overlap between the HMO/Point of Service and PPO networks.

The Plan has established the following access and availability standards and routinely measures performance against them.

- 85% of subscribers will have at least one primary care physician within 15 miles
- 95% of subscribers will have at least one of each type of high volume specialist within 30 miles
- 85% of subscribers will have at least one hospital within 15 miles
- 100% of all Independent Practice Associations/Medical Groups are required to provide ancillary care locations within their service area.
- One primary care physician per 1,200 combined Commercial and Medicare enrollees
- One obstetrician/gynecologist per 10,000 commercial enrollees
- One of each type of HVS per 20,000 enrollees

- Enrollees in need of emergent care are advised to seek care from the nearest facility, such that 100% of enrollees will receive emergency care immediately.
- 100% of enrollees in need of urgent care will be seen within 24 hours
- 90% of enrollees in need of routine care from a primary care physician will be seen within seven days
- 90% of enrollees in need of routine care from a specialist will be seen within 14 days
- 90% of enrollees in need of preventive care will be seen within 30 days
- In the absence of emergencies, medical offices should seek to limit wait time to 15 minutes after patient's scheduled appointment
- Providers will maintain sufficient hours of operation so as not to cause member-reported access/availability problems with an adverse effect of quality of care of medical outcome
- 100% of enrollees will have access to their primary care physician or covering physician 24 hours a day
- 100% of enrollees will have access to an answering service or machine with instructions for obtaining emergency care

The Plan monitors performance against these standards through GeoAccess studies, member and practitioner satisfaction surveys, after hours surveys of practitioners, appointment availability surveys and analysis of enrollee complaints and grievances, percent of panels that are open and request for PCP change due to access/availability problems. Performance for most of the access and availability indicators is near or above their standards. In addition, the plan has seen steady improvement in most of the indicators since 2003. The Plan also monitors performance at the county and Independent Practice Association/Medical Group to identify areas or groups in need of improvement. The Plan implements corrective action plans for those areas or groups whose performance is below standards.

The Access and Availability Workgroup is responsible for reviewing the access and availability standards, monitoring performance against them, identifying opportunities for improvement, and implementing correct action as necessary. The Access and Availability Workgroup reports to the Network Operations Committee. The Plan notifies enrollees and providers of the standards through the member handbook and provider manual, respectively.

UTILIZATION MANAGEMENT

The Plan has a comprehensive UM Program, which covers prior authorization for all inpatient care, specified outpatient surgical and medical procedures, and out of network specialty services. Of the 1.28 million enrollees in the Plan only about 70 thousand enrollees are managed by the Plan's internal UM Program. Delegated Independent Practice Associations/Medical Groups manage the vast majority of the remaining enrollees. All pharmacy requests that include prior authorization are processed by the Plan.

The following major committees addressing UM issues:

- Pharmacy and Therapeutics Committee - responsible for formulary development and management;
- Medical Policy Committee - responsible for the adoption and approval of medical necessity criteria for all medical services, including new technology adoption;

- Network Operations Committee- responsible for the oversight of delegates who are delegated UM decision-making; and
- Behavioral Health Oversight Committee - performs oversight of behavioral health vendor.

The Plan has a comprehensive set of performance measures that are used to monitor internal UM Program functions and delegate UM activities. These include HEDIS® measures as well as commonly accepted UM measures. The Plan monitors delegates on a quarterly basis with comprehensive utilization metrics. Through the Medical Management Reports the Plan provides this information to delegates on a regular basis.

A P P E N D I X D

D. SURVEY TEAM, PLAN STAFF INTERVIEWED, PROVIDERS INTERVIEWED

The Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Jennifer Gore	Counsel, Enforcement Division
Adama Iwu	Department Intern

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Linda Yazvac, MD	Quality Management Surveyor
Erick M. Davis MD, MPH, MBA	Utilization Management Surveyor
Jill Sanborn MPH, MHS, CHCA	Access and Availability of Services Surveyor
Rose Leidl	Grievances and Appeals Surveyor
Bernice Young	Grievances and Appeals Surveyor

Survey Plan officers and staff interviewed during the on-site survey at the Plan were:

Blue Shield of California	
Sharon Baughn, RN	Director, Appeals & Grievances
Andy Halpert, M.D.	Senior Medical Director, Network Medical Management
Jackie Ejuwa, Pharm.D.,	Manager, Clinical Prior Authorization
Tara Abrams, Pharm.D.	Senior Clinical Pharmacist, Quality Improvement
Lyle Swallow, Esq,	Associate General Counsel
Sue Stephenson, RN	Manager, Case Management
Jan Lea, RN	Manager, Delegation Oversight
Dolores Aisenberg, RN	QI Manager
Salina Wong, Pharm. D	Director, Clinical Pharmacy Programs
Wendy Lekavich	Director, Provider Relations
Deb Fleming, RN, MBA, JD	Director, Quality Improvement and Accreditation
Gifford Boyce-Smith, MD	Senior Medical Director, Quality Management
Karen Short, RN, JD	PQI Manager (PQI Nurse Specialist)

Provider representatives interviewed during the on-site survey at the Plan were:

Prospect Medical Group	
Richard Bach, MD	Chief Medical Director
Rosa Catalano, RN	Director, Medical Management
John Muir, Mt. Diablo Health Network	
Mike Kern, MD	Quality Improvement Medical Director
Martin Coyne, MD	Utilization Management Medical Director
Terry Jagow, RN	Quality Improvement Manager
Bev McMunn, RN	Utilization Management Manager
Katrina Gesh-Wilson	Chief Operating Officer

A P P E N D I X E

E. APPLICABLE STATUTES AND REGULATIONS

The following are the specific citations used in this Routine Medical Survey Report as the basis for the deficiencies:

GRIEVANCES and APPEALS

Deficiency #1: **The Plan does not consistently provide a clear and concise explanation of the Plan's decision.**

Citation:
Rule 1300.68(d)(3)
The plan's resolution, containing a written response to the grievance shall be sent to the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.

Deficiency #2: **The Plan does not immediately and consistently notify the complainant of the right to contact the Department regarding the urgent appeal.**

Citation:
Rule 1300.68.01(a)(1)
(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

(1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.

Deficiency #3: **The Plan does not consistently implement Independent Medical Review decisions in a timely manner.**

Citations:
Section 1374.34(a)
Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

Section 1367.01(h)((3)
Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

UTILIZATION MANAGEMENT

Deficiency #4: **The Plan does not consistently provide the Utilization Management (UM) criteria used or clinical reasons for denial, delay or modification decisions.**

Citation:
Section 1367.01(h)(4)
Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding clinical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

Deficiency #5: **For benefit denials, the Plan does not clearly describe in the denial letter the provisions in the Evidence of Coverage that exclude coverage of the requested service.**

Citation:

Section 1368(a)(5)

The Plan shall provide subscribers and enrollees with written responses with a clear and concise explanation of the reasons for the Plan's response involving the delay, denial, or modification of health care services, the Plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage..